



Building relationships. Building dreams. Building together.
Providing quality services to people with developmental disabilities.

Authorization for Release of Information

I hereby authorize the release of any/all confidential information pertinent to my care to Ikan, Inc. This includes psychological/social evaluations/reports, school records/IEP, clinical evaluations (occupational therapy, physical therapy, speech therapy) and any other related information that will assist Ikan, Inc. in providing me with quality services.

Organizations and persons authorized by me to release such information include but are not limited to the following: Any organization, company, person, or other entity involved in the planning or provision of my health care needs and or related services, either directly and/or on my behalf.

Special Note:

1. I understand that information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that this authorization is voluntary and may be revoked in writing to the provider above at any time, effective from the date of said written revocation; the revocation will not apply retroactively.

This authorization is good from the date of signature indicated below unless revoked in writing by me. A photocopy of this authorization will have the same force and effect as the original.

Printed Client Name

Client signature/Signature of person authorized to act in client's behalf /Date

Relationship to Client _____

Witness Signature/Date _____